Zdrowie Publiczne i Zarządzanie 2015; 13 (2): 141–149
www.ejournals.eu/Zdrowie-Publiczne-i-Zarzadzanie, doi:10.4467/20842627OZ.15.014.4317

The evolving concept of health promotion: definitions, outcomes and classification of interventions

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Acknowledgement

This publication arises from the project Pro-Health 65+ which has received funding from the European Union, in the framework of the Health Programme (2008–2013).

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Publication financed from funds for science in the years 2015–2017 allocated for implementation of an international co-financed project.

Abstract

The concept of health promotion was evolving from 70ies of 20th century in response to calls for increasing the effectiveness of measures undertaken for the improvement of health of individuals and societies. Although, a classical definition of health promotion was formulated in Ottawa Charter in 1986, the perception of this domain may still vary depending on different authors and organizations.

This paper brings some basis insights on approaches to systematising available definitions of health promotion as well as to classifying its interventions. Furthermore, the outcome model of health promotion is described in order to better reflect the relation between interventions undertaken under the umbrella of health promotion and possible short- and long-term results. Finally, the definitions of various levels of disease prevention are proposed and the discussion of similarities and differences between health promotion and disease prevention is included. The paper was developed with the intention of formulating theoretical basis for analysis of available evidence on effectiveness of health promotion and disease prevention interventions addressed to elderly audience.

Key words: **health promotion, disease prevention, outcome model, health promotion interventions**

Słowa kluczowe: **interwencje, model ukierunkowany na wyniki, promocja zdrowia, prewencja chorób**

Introduction

The concept of health promotion emerged as a new approach to the challenge of health maintenance and improvement. It offered a new quality of thinking about health with strong emphasis on its positive understanding and not only on avoiding diseases. After several decades of translation of health promotion doctrine into practice, it became obvious that health promotion interventions should be seen in the context of complex interrelationships encompassing citizens, communities, health care systems and surrounding environments. This paper was prepared in the context of international project focused on evidence search for health promotion interventions addressed to elderly persons. Thus, the approaches offering systematic thinking about definitions, outcomes and

interventions of health promotion are reminded. Furthermore, the concept of disesae prevention is discussed in search for differences and common elements with health promotion. Although, every model or classification is usually only some approximation of strategies applied in real life conditions, their knowledge may be helpful in assessment of available evidence in search of practical recommendations.

Origins

Author's experience indicates that in colloquial understanding, the term "health promotion" is sometimes used in relation to all activities that lead to the improvement of the health status of individuals or communities. Such interpretation is very extensive and encompasses many types of actions undertaken in the areas of public health and health care services. To some extent it reflects the fact that many national and international activities related to prevention, screening or even rehabilitation are carried out together under the umbrella of health promotion and disease prevention [1–6]. This may be understandable as the concept of health promotion as a discipline is still relatively recent and originates from initiatives undertaken in the 1970s [7, 8]. It may be seen as the next stage of thinking about health after the great undertakings in public health initiated during the second half of the 19th century. It is also a response to the trend of medicalization and the efforts for safeguarding the wellbeing of societies, which were observed in the second half of the 20th century. Health promotion proposed a change of focus from an individualistic perception of health, usually driven by the medical approach, to a wider view incorporating environmental, social and economic aspects [9]. The recognition of health promotion should also be considered in relation to the positive definition of health which was included in the preamble of the WHO constitution formulated in 1946 [10].

A new chapter in our understanding of the health condition of individuals and nations started with the report prepared in 1974 by Marc Lalonde, the Minister of National Health and Welfare in Canada [7]. One of key statements in this report was related to the concept of health fields. According to the report, there are four such fields: human biology, health care organisation, lifestyle, and environment. Lalonde suggested that the greatest gains in health improvement may be achieved through changes in lifestyle and environment and not through investing in health care organisation. This approach was challenging in the era of a belief in the medical approach to improving health and directing considerable efforts to health care organisation [11].

Even though the report gained high visibility in communities responsible for shaping the health care landscape on national and international levels, it seems that thinking about the role of health care organisation in the safeguarding of health of societies prevailed for several decades [12].

The progress seen in the development of the concept of health promotion was to some extent related to the dissatisfaction with the level of health benefits achieved from ongoing investments in health care systems and questioning of effectiveness of medical model in 1970s [13]. Efforts to establish health promotion as a legitimate approach to the improvement of health of individuals and communities led to the First International Conference on Health Promotion held in Ottawa in November 1986. During the conference, the Ottawa Charter was drafted, including a definition of health promotion and proposing a set of measures which should be taken to achieve its objectives [14]. It was treated as a roadmap for countries accepting the aims designated in the Declaration of Alma Ata prepared during the WHO Assembly in 1978 [15].

The definition formulated in the Charter states that health promotion is "the process of enabling people to increase control over, and to improve, their health". The Charter also assumed that health should be treated as a resource rather than the objective of living. Among the prerequisites for health, the Charter enlisted peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity. These prerequisites can be attained through three types of strategies: advocacy, enabling and mediation for health. Advocacy is perceived as an approach leading to a favourable change of all relevant factors influencing health. It was further defined as "a combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme" [16]. Enabling is used in the context of people's ability to control "things that determine their health". And finally, mediation is necessary for achieving agreement of all stakeholders who should cooperate in order to have an impact on the prerequisites for health. According to the definition proposed by Nutbeam in the Health Promotion Glossary, mediation is a process through which the different interests (personal, social, economic) of individuals and communities, and different sectors (public and private), are reconciled in ways that promote and protect health [17]. The Charter also defined key action types for health promotion. They include building a healthy public policy, creating supportive environments, strengthening community actions, developing personal skills, and reorienting health services. The Ottawa Charter was one of the greatest milestones in developing modern strategies for health promotion. However, the definition of health promotion and actions required were described on a general level, which needs to be translated into practical measures.

Definitions

In recent decades, many definitions of health promotion have been proposed in literature. In his report from 1974, Lalonde described five strategies for the improvement of health of Canadians including a health promotion strategy. It should be "aimed at informing, influencing and assisting both individuals and organizations so that they will accept more responsibility and be more active in matters affecting mental and physical health".

In 1980, Green referred to health promotion as "any combination of health education and related organizational, political and economic interventions designed to facilitate behavioural and environmental changes that will improve health" [18].

The definition included by Nutbeam in the "Health promotion glossary" published under the auspices of the WHO Regional Office for Europe in 1985 stated that health promotion is "the process of enabling people to increase control over the determinants of health and thereby improve their health" [19]. This definition is nearly identical as the one included in the Ottawa Charter; in the latter, "determinants of health" are replaced by "health" [14]. The Glossary published in 1998 cites the definition derived from the Ottawa Conference on Health Promotion.

According to Goodstadt et al., health promotion is "the maintenance and enhancement of existing levels of health through the implementation of effective programs, services and policies" [20].

The definition formulated by Green & Kreuter in 1991 once again emphasises educational activities, although environmental interventions are also important. This definition describes health promotion as "the combination of educational and environmental supports for actions and conditions of living conducive to health" [21].

The European Committee for Health Promotion Development in the working document from 1998 assumed that health promotion is the promotion of wellbeing and the prevention (or reduction in the probability) of disease or ill health [22].

In turn, according to the Dictionary of Public Health Promotion and Education published in 2004 by Modeste and Tamayose, health promotion is a combination of health education and specific interventions, such as anti-smoking campaigns, breast health month and diabetes awareness, at the primary level of prevention designed to facilitate behavioural and environmental changes conducive to health enhancement and health reduction [23].

In 2008, Tannahill proposed a new definition of health promotion which "should be understood as sustainable fostering of positive health and prevention of ill-health through policies, strategies and activities in the overlapping action areas of socioeconomic, physical and environmental factors, equity and diversity, education and learning, services, amenities and products as well as community-led and community based activities" [24].

Finally, O'Donnell in the Editor's Notes Section of the American Journal of Health Promotion from 2009 proposed definition of Health Promotion 2.0. This new definition emphasises the importance of motivation in striving for optimal health and necessary support allowing people to change their lifestyle in order to achieve it [25].

In his presentation on the evaluation of health promotion interventions delivered during the national conference in Brisbane in 1995, Goodstadt pointed out that empirical evidence should concern the impact on instrumental (mediating) health-related objectives and on terminal (ultimate) goals [26]. This approach to health promotion objectives was further explored by Rootman et al., in the chapter co-authored by Goodstadt, included in the book published under the auspices of the WHO Regional Office Europe in 2001 [27]. The authors propose a more systematic approach to understanding the available definitions of health promotion based on the distinction of the objectives mentioned above [27].

The use of two categories of objectives, instrumental and terminal (ultimate), stems from the nomenclature of values proposed by Rokeach [28]. According to this approach, terminal or ultimate objectives of health promotion should be seen in the long-term perspective and they refer to the "desired end-state of health or wellbeing". The achievement of health as the ultimate outcome would require designating and reaching instrumental objectives. In an example mentioned by Rootman et al., smoking cessation would be an instrumental objective leading to improved health measured by life expectancy or quality of life. Instrumental objectives may be achieved as a result of instrumental processes triggered by instrumental activities. In this sequence, health promotion interventions such as education activity or behaviour intervention initiate processes such as reaching higher motivation or self-efficacy, which can lead to the desired instrumental objective, in this example smoking cessation.

In most definitions of health promotion, health and/or wellbeing are designated as terminal objectives. As for the activities, processes and instrumental objectives, we can see a higher diversity across definitions which were proposed during the last 50 years. The perception of health promotion as a chain starting from instrumental activities through instrumental processes and objectives to terminal objectives is particularly feasible when we want to better understand the complex environments of various actions carried out under the umbrella of health promotion.

Existing definitions of health promotion include elements of this health promotion sequence. In Lalonde's definition from 1974, instrumental activities included informing, influencing and assisting individuals and organisations. They should result in accepting more responsibility and being more active in matters affecting mental and physical health.

The definition proposed in the Ottawa Charter identifies a process specific for health promotion, which is "enabling people"; the instrumental objective would be "increasing control" and the ultimate outcome "improving health". In the definition formulated by Green in 1980 [18], we can trace even more elements of the health promotion sequence. Activities here would be "health education and related organisational, political and economic interventions". Processes are not mentioned; however, the instrumental objective is facilitating behavioural and environmental changes, and the ultimate outcome is improving health. In the definition of Goodstadt et al. from 1987, instrumental activities cover the "implementation of effective programs, organisation of services and policies" in order to achieve the ultimate objective which is maintaining and strengthening health status [20].

Most definitions mention ultimate goals for health promotion, while instrumental elements of the health

promotion sequence are changeable. Some authors refer to specific activities, while others point out instrumental processes, such as enabling people, increasing their activity and convincing them to accept more responsibility, or instrumental objectives, such as better standards of living and positive changes of behaviour and/or environment.

Some authors maintain that health promotion is still not a discipline [29, 30]. O'Neil and Stirling argue that it is not defined sufficiently well, nor differentiated from other similar fields to establish its academic position [31]. The complexity of the concept of health promotion may be frustrating for people who wish to obtain a clear vision of the scope and types of interventions and strategies available. According to Best, an understanding of the multidimensional and nuanced landscape of health promotion should be based on systems thinking [32]. Systems thinking emerged as a response to the growing complexity of problems appearing in various disciplines, including health, in order to enable understanding of relationships occurring in a system and to propose interventions which could be evaluated on the system level. This approach could be efficient in tackling complex health problems [33, 34].

Best points out that health promotion, intervention and evaluation share key features of complex systems including self-organisation and adaptation to change, driven by interactions between components and governed by feedback; additionally, the nonlinearity and unpredictability of changes in one area leads to unexpected changes in other areas. Health promotion targets complex problems which require intervention and engagement of many stakeholders across many relevant levels. Thus, certain authors postulate that the complexity paradigm should be integrated in health promotion as a discipline [35].

Outcomes

The report on the effectiveness of health promotion prepared under the auspices of the International Union for Health Promotion and Education (IUPHE) in 1999, proposed an outcome model for health promotion [36]. The model was developed as a tool for a systemising searche for evidence of health promotion interventions, and to some extent it repeats the sequence from health promotion activities to ultimate objectives described earlier in the context of defining health promotion [19]. However, the nomenclature used here is based on various levels of outcomes resulting from health promotion activities. Health and social outcomes remain the highest levels of outcomes. Health outcomes may be measured with morbidity, disability or mortality, and social outcomes with quality of life, functional independence and equity. Lower levels of outcomes are formed of intermediate health outcomes, which correspond to modifiable determinants of health such as healthy lifestyles, effective health services and health environments. Finally, the lowest level covers health promotion outcomes corresponding to measures of intervention impact. The model proposes three kinds of such measures: health literacy, social action and influence, and healthy public policy and organisational practices. Health promotion outcomes may be achieved by health promotion actions including education, social mobilisation and advocacy. The general structure of the model is shown in **Table I**. Examples of lifestyles encompass smoking, food choices, physical activity and alcohol intake. Effective health services rely on the provision of preventive services and access to health services. Finally, the measures of healthy environments cover safe physical environment, economic and social conditions, adequate food supply and restricted access to tobacco and alcohol. The measures, which reflect the impact of interventions, correspond in this model with health promotion outcomes. The three main categories of this type include health literacy, social action and influence, and healthy public policy and organisational practice.

Interventions

A systemic approach to health promotion requires a typology of available interventions. Depending on the theoretical framework adopted and sometimes on field of interests, the classifications may differ significantly. Some classifications are proposed in broad public health or health programmes, while others are specific to health promotion. Furthermore, the methods used and many other criteria can be employed when classifying interventions, e.g. level of delivery, targeted audience, place of delivery or organisation carrying out the intervention.

McKenzie et al. proposed terminology of health promotion interventions stemming from earlier definitions developed within the US Centers of Disease Control and Prevention [37]. This classification provides a comprehensive view of possible interventions, even though its dimensions are rather arbitrary. It distinguishes seven main types of health promotion intervention strategies:

- health communication;
- health education;
- health policy/enforcement;
- environmental change;
- health-related community service;
- community mobilisation;
- other.

Health communication relies on communication strategies applied in order to inform and influence individual and community decisions that affect health. It may take various forms, e.g. mass media, media advocacy or public relations. It should be stressed that most health promotion interventions use health communication means, at least to some extent. Health education, according to Green and Kreuter's definition from 2005, is "any planned combination of learning experiences to predispose, enable and reinforce voluntary behaviour decisions conducive to health of individuals, groups and communities". To some extent health communication and health education overlap. The main difference is that health education assumes some type of planned learning experience.

According to McKenzie et al. [37], health policy and enforcement strategies include executive orders, laws, ordinances, judicial decisions, policies, regulations, rules and position statements. They indicate that all these strat-

Health & Social Outcomes	**Social outcomes** measures include: quality of life, functional independence, equity		
	Health outcomes measures include: reduced morbidity, disability, avoidable mortality		
Intermediate Health Outcomes (modifiable determinants of health)	**Healthy lifestyles** measures include: tobacco use, food choices, physical activity, alcohol and illicit drug use	**Effective health services** measures include: provision of preventive services, access to and appropriateness of health services	**Health environments** measures include: safe physical environment, supportive economic and social conditions, good food supply, restricted access to tobacco, alcohol
Health Promotion Outcomes (intervention impact measures)	**Health literacy** measures include: health-related knowledge, attitudes, motivation, behavioural intentions, personal skills, self-efficacy	**Social action and influence** measures include: community participation, community empowerment, social norms, public opinion	**Health public policy and organisational practice** measures include: policy statements legislation, regulation, resources allocation, organisational practices
Health Promotion Actions	**Education** examples include: patient education, school education, broadcast media and print media communication	**Social mobilisation** examples include: community development, group facilitation, technical advice	**Advocacy** examples include: lobbying, political organisation and activism, overcoming bureaucratic inertia

Table I. *An outcome model for health promotion.*

Source: Reproduced with permission from A Report for the European Commission by the International Union for Health Promotion and Education. The Evidence of Health Promotion Effectiveness. Shaping Public Health in a New Europe. Part Two, Evidence Book, 1999 [36].

egies are characterised by the fact that a decision is made by "an authoritative person, agency/organisation, or body that is presented in a statement or guideline intended to direct or influence the actions or behaviours of others".

Environmental changes are usually focused on removing barriers which exist in a community and aim to drive changes in health-related behaviour in a favourable direction. In general, it is expected that environmental change strategies will result in such modifications of the environment that making decisions which are beneficial for health will be easier. The environment has a broad meaning, and may denote physical, economic, social or political environments.

Health-related community service strategies include services, tests or treatments carried out in order to improve health of priority populations. Examples include child immunisations or screening for chronic diseases, e.g. diabetes. McKenzie et al. emphasise that such interventions usually rely on a strong involvement of health care providers [37].

Community mobilisation as a health promotion intervention should help communities to identify and undertake appropriate actions in relation to shared problems. McKenzie et al. distinguish two types of community mobilisation strategies: community organisation and building, and community advocacy [37]. The latter assumes involving citizens in institutions or decision which have an impact on their lives.

Other interventions used in health promotion include behaviour modification activities, organisational culture activities, incentives and disincentives, and social activities such as support groups and buddy systems, social gatherings and social networks.

Another perspective on intervention undertaken within health promotion is offered by the public health pyramid model. Although it is not limited to health promotion, it may be valuable to consider the scope of planned interventions according to levels of a pyramid to better understand the related challenges and consequences. The public health pyramid model was first developed by the US Maternal and Child Health Bureau of the Health Resources Services Administration in order to classify services developed with maternal and child health improvement programmes [38] The version adopted by Issel [39] includes four levels, of which the top three are related to health services. The basic level is formed by infrastructure services for health care systems and public health systems. These services include the provision of skilled professionals, availability of appropriate legislation, and technological and information resources.

The first health-related level in the pyramid is formed by population-based services, which are services delivered to entire populations, e.g. immunisation programmes addressed to all children in the country, or food safety measures. Enabling services are placed next. They should be understood as health and social services supporting

the health of groups of individuals distinguished by certain features, e.g. affected by the same disease or class of diseases. Nutrition education programmes carried out by schools, or transport to medical centres provided by the community, can be examples of such services. Finally, direct health care services are placed at the top of the pyramid. They are delivered to individuals and include services such as medical care or pharmacy. The public health pyramid model may be used for better understanding of the challenges related to the interventions and strategies during programme planning and evaluation. In this section, three classifications of interventions are described.

Westmaas et al. propose four levels of health promotion and disease prevention interventions: individual, organisational, community and societal [40]. Of course, interventions maintained on societal or population level should exert the greatest influence, although their cost-effectiveness may be a real challenge. Apart from the scope of the intervention, which increases from individual to societal, the level of interaction, increasing in the opposite direction, can be used as a dimension of classification. As Westmaas et al. address "interventions promoting health and preventing illness", they also propose a classification of interventions based on their position in the continuum from health to illness based on primary, secondary and tertiary levels [40].

Another approach to the classification of health-related interventions was developed by Issel [41]. She proposed amended typology originating from that developed by Grobe and Hughes in 1993 [42]. It consists of eight categories including treating, assessing, coordinating, monitoring, educating, counselling, coaching and giving tangibles. Applying this typology to the public health pyramid model means we can obtain a matrix of potential health interventions depending on target audience and type of service.

Health promotion and disease prevention

In the Health Promotion Glossary from 1998, disease prevention is defined as "measures not only to prevent the occurrence of disease, such as risk factor reduction, but also to arrest its progress and reduce its consequences once established" [17]. Nutbeam also indicates that disease prevention may be used as a complementary term to health promotion, but it is defined separately. He also points to the fact that it deals with subjects or populations with "identifiable risk factors, often associated with different risk behaviours". Nutbeam also refers to three levels of prevention: primary prevention (precluding the initial occurrence of a disorder), secondary, and tertiary (focused on arresting or delaying existing disease and its effects, reducing relapses and developing chronic consequences of disease) [17].

Primary prevention focuses on the prevention of the onset of disease, usually through risk reduction, e.g. by changing behaviour. Secondary prevention aims to control the disease before it manifests clinically. Screening can be an example of secondary prevention. Finally, tertiary prevention applies when the patient has developed the disease, and aims to reduce its negative impact on their life, e.g. through affecting their functional status or quality of life [43].

According to the Background Paper issued by the National Public Health Partnership in 2001, prevention is an "action to reduce or eliminate or reduce the onset, causes, complications or recurrence of disease" [44].

The document defines primary prevention as "the protection of health by measures which eliminate causes and determinants of departures from good health and control exposure to risk". Furthermore, primary prevention aims to reduce the incidence of diseases. The document defines secondary prevention as "the measures available to individuals and populations for the early detection and prompt and effective intervention to correct departures from good health. It is expected that secondary prevention will decrease the rate of confirmed cases in the community". Finally, tertiary prevention relies on "the measures available to reduce and eliminate long-term impairments, disabilities and complications from established disease, and to minimise suffering caused by existing departures from good health" [44].

The terms "health promotion" and "disease prevention" are used jointly or interchangeably by many organisations and professionals. Some authors indicate that the concept of disease prevention is well delineated, whilst the concept of health promotion is still elusive [45]. Historically, the appearance of health promotion signified a transition from tradition of "old public health" which focused on disease prevention to "new public health" associated with interdisciplinary efforts involving the environment and assuming a broader understanding of health than only an absence of disease. Although the definition of health as a state of wellbeing and multidimensional satisfaction was formulated many decades ago, common thinking about health tends to associate it with an absence of disease. Thus, disease prevention is a logical consequence of achieving it. If we adhere to the positive definition of health, health promotion should not only protect from developing diseases, but also support and improve health. Thus, prevention understood as avoiding specific diseases has a more narrow meaning and could be included in the concept of health promotion, although it is only part of it.

Combined thinking about health promotion and disease prevention can also be seen in some health promotion definitions. In 1985, Tannahill proposed a model of health promotion covering three domains: health education, health protection and disease prevention [46]. The author uses the definition of "health protection" included in the report from the US Department of Health, Education and Welfare from 1978 [47]. According to this definition, health protection meant "legal or fiscal controls, other regulations and policies, and voluntary codes of practice, aimed at the enhancement of positive health and the prevention of ill health".

Tannahill postulated that health promotion should increase positive health and prevent ill health [46]. The model proposed by Tannahill was visualised as a Venn diagram with three overlapping circles for these do-

mains. The diagram shows seven fields resulting from overlapping circles, described as:

- positive health education, e.g. actions influencing lifestyle;
- positive health protection, e.g. implementation of workplace antismoking policies;
- positive health education, e.g. influencing behaviour with a positive impact on health or developing health-related life skills;
- preventive services, e.g. immunisation, cervical screening;
- preventive health education, e.g. leading to increased use of preventive measures;
- preventive health protection, e.g. fluoridation of water;
- health education for preventive health protection, e.g. reaching for support for positive health promotions measures.

While Tannahill's model was criticised for being simplistic, being more of a linguistic exercise than a real model, and for its emphasis of medical context, in its time it helped to further conceptualise the scope of activities undertaken as health promotion interventions [46].

Some authors who see prevention as a mainly disease-driven concept do not include health promotion in their considerations. Instead they propose three types of prevention: universal, selective and indicated preventive intervention [48]. Universal preventive measures would be addressed to all people, and in general they could be applied without professional advice or assistance. As examples of such measures, Gordon indicates adequate diet, dental hygiene, use of seatbelts in cars and smoking cessation, as well as immunisations. The universality of these measures stems from the fact that their application to entire populations results in higher benefits than costs and risks. Selective preventive measures would be recommended only to selected subgroups in which the risk of developing specific diseases is particularly high. Among such measures, Gordon indicated (in 1983) annual influenza immunisation for the elderly and active rabies immunisation for veterinarians. Finally, indicated preventive measures would be appropriate only for individuals with confirmed risk factors, conditions or abnormalities putting them at high risk justifying preventive action. In this classification, universal preventive measures as understood by Gordon largely correspond to the modern understanding of health promotion activities [48].

Bloom and Gullotta attempted to match preventive actions to stages of disease; in this scheme health promotion was placed as a preventive activity undertaken during the stage of susceptibility when "the prerequisite conditions of the disease emerge, but are not yet operating as part of the disease entity" [49]. In this context, health promotion relies on "furthering health and wellbeing through general measures (like education, nutrition, provision of social services) aimed at host populations in relevant environments". As well as health promotion, this stage should maintain "specific protections" which are "measures applicable to a particular disease in order to intercept the pathogenic agent". Latter stages of disease are specified as preclinical states and acute clinical stages, with preventive activities including early recognition and prompt treatment. In the next disease stage, known as the post-acute clinical or chronic stage when "residual effects of disease continue to be present and problematic, or remission of symptoms (but not of the disease)", prevention is based on limiting potential disabilities. Finally, during the stage of termination of the clinical stage, only patient rehabilitation is possible to obtain the best achievable level of functioning. Placing preventive activities according to the stages of disease reflects the medical approach to health [49].

A similar medically-driven approach was also proposed by Sosic and Donev [50]. They place health promotion within primary prevention when considering the continuum spanning from full health to death. According to Donev et al., primary prevention should be assigned to the state of health or prepathogenesis and encompass measures for health promotion and measures for health prevention within specific care. Relevant actions should be performed by community with non-health sectors, individual and population through self-care and health service through the primary health care and specialised preventive medical care. As for secondary and tertiary prevention, they are appropriate for the state of disease (pathogenesis) and should include, for secondary prevention, measures for early detection, prompt treatment and restriction of any potential disability, and for tertiary prevention – measures for rehabilitation and support. Both secondary and tertiary prevention activities should be performed by health care systems through primary, secondary and tertiary organisations. Tertiary prevention should be carried out by health care services and rehabilitation services, and – if applicable – by social, humanitarian and educational institutions and services and non-governmental organisations (NGOs).

According to Tengland [51] health promotion and disease prevention are distinct concepts but they are related through a causal connection. He also claims that "it is possible to promote health without preventing disease..., but it is not possible to prevent disease without promoting health", although "it is usually the case that when we promote health we also prevent disease". Such interpretation seems logical, as health promotion as a concept remains in line with broader thinking about health, not only as an absence of disease, but also as wellbeing in all possible dimensions. However, in practice, differentiation between health promotion and disease prevention could be difficult, even though they can be distinguished conceptually [52].

Conclusion

The approach to the classification of evidence in health promotion remains a challenging task. Even after several decades of ongoing efforts to establish the rationale and implement health promotion strategies in practice, its concept continues to evolve. It is clear that the delivery of health promotion interventions requires not only an appropriate assessment of the needs of po-

tential target audiences but also the consideration of complex interactions occurring in the community, environment and health care systems. There is also ongoing discussion about the relationship between health promotion and disease prevention. Although the two domains are conceptually different, interventions undertaken within both domains overlap to a large extent. Existing typologies of health promotion interventions may facilitate the classification of evidence, but it should be remembered that they usually offer a simplified view of the field. Health promotion programmes carried out in communities are based on combined and multidimensional strategies.

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Co-funded by
the Health Programme
of the European Union

This publication arises from the project Pro-Health65+ which has received funding from the European Union, in the framework of the Health Programme (2008–2013).